



TEXAS DEPARTMENT OF INSURANCE

Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

Laurence Ligon, M.D.

Respondent Name

TASB Risk Management Fund

MFDR Tracking Number

M4-15-3809-01

Carrier's Austin Representative

Box Number 47

MFDR Date Received

July 22, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "... this request was in response to a \$750.00 reduction of the \$2200.00 for the Designated Doctor Exam performed on December 3, 2014... our request was denied and we are seeking the balance owed to us."

Amount in Dispute: \$750.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Per the DWC32 request, we asked the designated doctor to address maximum medical improvement (MMI), impairment rating (IR) on the right hand, return to work and extent of injury..."

... There is no documentation, indication of testing, or DRE information to determine the IR portion for the unrelated conditions of; hypertension, asthma, gerd, anxiety and overactive bladder. The doctor's note indicates the injured worker would not be at MMI for these conditions as there has been no treatment. Additionally, there is no impairment rating for these conditions."

Response Submitted by: TASB Risk Management Fund

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 3, 2014	Designated Doctor Examination	\$750.00	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204 sets out the guidelines for billing and reimbursing Division-specific

services.

3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - P12 – Workers’ compensation jurisdictional fee schedule adjustment.
 - W3 – Additional payment made on appeal/reconsideration.
 - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

Issues

1. What is the Maximum Allowable Reimbursement (MAR) for the disputed services?
2. Is the requestor entitled to additional reimbursement?

Findings

1. While examinations for multiple impairments, extent of injury, and return to work were included on the Medical Fee Dispute Resolution Request (DWC060), the amount requested for these examinations was \$0.00. Therefore, these charges will not be considered.

Per 28 Texas Administrative Code §134.204 (j)(3), “The following applies for billing and reimbursement of an MMI evaluation. (C) An examining doctor, other than the treating doctor, shall bill using CPT Code 99456. Reimbursement shall be \$350.” The submitted documentation indicates that the requestor performed an evaluation of Maximum Medical Improvement. Therefore, the correct MAR for this examination is \$350.00.

Per 28 Texas Administrative Code §134.204 (j)(4), “The following applies for billing and reimbursement of an IR evaluation. ... (C)(ii) The MAR for musculoskeletal body areas shall be as follows. ... (II) If full physical evaluation, with range of motion, is performed: (-a-) \$300 for the first musculoskeletal body area.” The submitted documentation indicates that the requestor provided an impairment rating, which included a musculoskeletal body part, and performed a full physical evaluation with range of motion of the right upper extremity. Therefore, the correct MAR for this examination is \$300.00.

2. The total MAR for the disputed services is \$650.00. The insurance carrier paid \$650.00. Therefore, no further reimbursement is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

_____ Signature	Laurie Garnes _____ Medical Fee Dispute Resolution Officer	August 31, 2015 _____ Date
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YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.